DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 1999
ANNUAL PERFORMANCE PLAN SUMMARY

GOVERNMENT PERFORMANCE AND RESULTS ACT

HHS FY 1999 ANNUAL PERFORMANCE PLAN SUMMARY

Government Performance and Results Act

(Technical Note: The Department of Health and Human Services is a large, decentralized Agency that administers approximately 300 program activities. To best accommodate the linkage of performance goals and measures for program activities to the budget requests for these programs, HHS has incorporated the annual performance goals and measures into the budget submissions for the HHS operating divisions that administer the programs. To view the performance goals and measures for individual program activities, readers are referred to the annual performance plans included in the Congressional budget justifications for the HHS operating divisions.)

INTRODUCTION

The Department of Health and Human Services (HHS) is a large Federal Department that provides leadership in the administration of programs to improve the health and well being of Americans and to maintain the U.S. as a world leader in biomedical and public health sciences. The programs of the Department impact all Americans either through direct services, the benefits of advances in science, or information that helps them choose medical care, medicine and food. Through Medicare and Medicaid, for example, HHS oversees the administration of the nation's largest health insurance programs, serving an estimated 72 million Americans. Through numerous grants and other financial arrangements with public and private service providers, HHS is committed to improve health and human service outcomes and the economic independence of individuals and families throughout the U.S.

Partnership

As set forth in the laws that established the programs administered by HHS, partnership in administration is the central and fundamental management approach for program implementation and service delivery. Virtually all of the approximately $400 billion dollars that will be expended for HHS programs in FY 1999 will be spent not by HHS employees but by program partners. The States, not the Administration for Children and Families (ACF), spend the funds that support the income assistance provided under Temporary Assistance for Needy Families (TANF). More than $8 out of every $10 appropriated to the National Institutes of Health (NIH) goes to the scientific community at large. Large fiscal agents such as Blue Cross and Blue Shield and Aetna pay the doctors, hospitals, and other health care providers that serve Medicare and Medicaid beneficiaries. It is through collaboration with States, local and tribal governments, and non-governmental partners that HHS must set and accomplish the program goals and objectives that produce results for people with the enormous annual investment entrusted to the Department. The diversity and scope of HHS programs are also reflected in the large number of Congressional appropriations and authorizing committees and subcommittees involved in the determination of HHS resources and program strategies.

Program Strategies

The primary and most substantive means of producing results with these investments are not the management strategies and processes that are developed by Federal program managers, although these can and do improve the efficiency and effectiveness of service delivery for programs that serve people. Rather, the significant Federal strategies that produce the results that GPRA seeks to measure are the program strategies that the Congress has authorized in legislation and that HHS and its partners execute. The means of success for HHS are its programs in basic and applied science, public health, income support, child development, and the financing and regulation of health and social services.

HHS Annual Performance Assessment Strategy

As a result of these factors, HHS's performance assessment strategy focuses on the results that HHS and its partners produce through the programs and resources entrusted to them. HHS's annual performance plans are not internal management documents that seek to assess only the methods and strategies employed to issue grants, contracts or cooperative agreements. Rather, they are documents that inform the Congress and the public about:

- the program goals and objectives of ***HHS and its partners***,
- the HHS ***program strategies that are defined in large part by law***, and
- the measures of ***program results that affect people***.

The HHS FY 1999 Annual Performance Plan consists of this summary and the annual performance plans of HHS components. The summary provides the overall Departmental context for all of the plans. It illustrates how the performance goals and measures for HHS programs support the HHS strategic plan. It addresses the very significant performance measurement challenges that HHS and other complex Federal agencies face in successfully implementing the Government Performance and Results Act. The annual performance plans for each of HHS's components include the detailed performance goals and measures for the Department's program activities, and they provide the link to the budget that is critical to the GPRA requirements for annual performance plans.

LINKAGE WITH THE HHS STRATEGIC PLAN

As indicated in the HHS Strategic Plan submitted to the Congress in compliance with the GPRA on September 30, 1997, the Plan is the first and guiding element in HHS performance management under GPRA. It defines as the Mission of HHS:

"To enhance the well-being and health of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services."

To carry out this mission, the HHS Strategic Plan identifies six goals that serve as the current performance management framework of the Department:

- Reduce the Major Threats to the Health and Productivity of All Americans;
- Improve the Economic and Social Well-being of Communities, Families, and Individuals in the United States;
- Improve Access to Health Services and Assure the Integrity of the Nation's Health Entitlement and Safety Net Programs;
- Improve the Quality of Health Care and Human Services;
- Improve Public Health Systems; and
- Strengthen the Nation's Health Sciences Research Enterprise and Enhance Its Productivity.

CROSSCUTTING PROGRAMS AND GOALS

The link between the Annual Performance Plans and the HHS Strategic Plan also serves HHS as a resource for the identification and achievement of crosscutting goals and objectives for programs administered by the Department. At the broadest levels of achievement, the goals and objectives of the strategic plan are crosscutting and are supported substantively by an array of program activities and detailed performance goals. The Strategic Plan provides the framework for HHS programs and the performance goals and measures included in the HHS annual performance plans. The performance goals and measures that support the Strategic Plan are not the same from program to program, but are complimentary and consistent with the overall direction of the Plan. These differences from program to program reflect a number of characteristics that make programs unique, such as differences in intervention modes, service providers and service populations.

Throughout, the HHS plans also address instances of program coordination with other Federal agencies. In particular, the Strategic Plan cites day-to-day staff contact with other agencies in its discussion of ***"Improving External Coordination,"*** which makes reference to: "cooperation with the Department of Education on substance abuse prevention activities in schools, work with the Department of Transportation to develop ways to help welfare recipients obtain affordable transportation to the workplace, and partnerships with the Departments of Justice and Labor to implement the Health Insurance and Portability and Accountability Act."

For broader coordination and consistency of performance goals across Federal agencies, HHS views these first GPRA annual performance plans of Federal agencies as a significant resource

that will allow for the identification of complimentary and, perhaps, duplicative program activities or strategies. The sharing of plans during this first year of implementation will provide the information that has been lacking to identify overlap and duplication, but, more significantly, opportunities for greater interagency coordination. This has already begun through the GPRA implementation process. HHS participates in a number of interagency performance measurement coordination groups that are seeking consistency and continuity across functional and program lines. For example, a number of Federal regulatory agencies have organized their efforts over the last year to identify consistent methods of performance measurement. Similarly, Federal research agencies have for several years been attempting to tackle perhaps the most difficult performance measurement challenge for the Federal government. The efforts of these groups will be enhanced when they can finally share the detailed plans that have been produced for FY 1999.

THE PERFORMANCE PLAN AND THE BUDGET

Just as OMB Circular A-11, Part 2, has stipulated that "the program activity structure is the foundation for defining and presenting performance goals and indicators," HHS has determined that the Budget of HHS provides the necessary structure for the development and presentation of an annual performance plan for a Department that administers some 300 program activities. The GPRA and OMB Circular A-11, Part 2 call for a process in which annual performance plans become an integral part of agency budget requests. HHS has elected from the outset to incorporate its Annual Performance Plan directly into the HHS Budget. The decision to present performance information in the budget reflects HHS's intent to enhance its decision making with performance measurement information, and to be attentive to the needs of Congressional committees that play a role in the Department's budget.

There are other significant advantages to incorporating the Annual Performance Plan into the HHS Budget. The Budget routinely describes program activities and specifies associated resource needs; this is information that is also required by GPRA for inclusion in annual performance plans. Combining the performance plan and the budget not only minimizes burden on program managers but also ensures the consistency of information used for budget and performance planning purposes. Finally, because the HHS Budget routinely covers all HHS program activities, including the performance plan in the Budget provides the framework to ensure that performance information fully covers these activities as well.

As a result, just as the HHS budget request is presented in multiple volumes that address the resource needs and justifications of the individual operating and staff components of HHS, so the HHS annual performance plan is presented in the same manner. The detailed and substantive information that fully explains program-level performance is included in the budget presentations and annual performance plans of each agency. A thorough understanding of HHS program-level performance information requires the study of the annual performance plans included in the Congressional budget justifications of the HHS components.

ANNUAL PERFORMANCE MEASUREMENT CHALLENGES FOR HHS

As the General Accounting Office observed in its March 1997 Report, *"The Government Performance and Results Act: 1997 Government Wide Implementation Will Be Uneven,"* performance measurement for HHS under the GPRA rubric will be a developmental and iterative process. Although HHS has identified significant and substantive performance information across the Department, there will be performance information gaps for some program activities, particularly in this first year of full implementation. For example, it is not feasible for the Health Care Financing Administration (HCFA) to develop representative outcome and impact performance goals and measures for the Medicaid program for FY 1999. Because Medicaid is not solely a Federal program, but one financed in partnership with the States and administered by the States, it is essential that the States participate actively and with significant authority in the development of performance goals and measures for this program. As a result, HCFA requested, and the Office of Management and Budget approved, a waiver from defining performance goals and measures for the Medicaid program in the FY 1999 HHS Annual Performance Plan.

Data Challenges

The range and diversity of programs managed by the Department have contributed to one of the most critical challenges in the implementation of GPRA within HHS. The absence in many cases of timely, reliable, and appropriate data from performance partners is a critical limiting factor in developing performance objectives, goals and indicators for HHS programs. As is discussed in the Department's Strategic Plan, this issue applies throughout the Department for many program activities, the details of which are explained in component plans.

It is related significantly, however, to the decentralized and distributed nature of program implementation throughout the Department and to the extensive involvement and authority of non-Federal partners in program implementation and management. Existing data systems were most frequently established to monitor the use of resources and to provide aggregate data that does not capture the outcomes of activity. In addition, many Federal surveys are not conducted annually and do not provide state-specific data or data that tracks special population groups. As a result, a number of HHS programs will rely initially on data collected for other purposes that may not always meet GPRA needs.

Data validation, which is a fundamental GPRA requirement, will also be a challenge for many HHS components. Because the circumstances and sources of performance information are so varied across the Department, the summarization of data validation is not feasible. It is addressed by the individual HHS components in their performance plans. Nevertheless, a common attribute of validation across the Department is that it will be resource intensive and require extensive coordination with performance partners.

For a number of program activities, there are outcome goals and objectives for which baseline and target data are not currently available. This is related to the issue of data validation, but also warrants a separate mention because the establishment of baselines is a fundamental requirement of GPRA. This issue alone explains the necessity of viewing GPRA implementation as an iterative process.

Types of Measures: Outcome, Output and Process

To provide for the assessment of both program performance and program results, HHS has included a balance of outcome, output and process measures throughout the annual performance plans. Because the Department seeks to improve the health and well-being of individuals through most of its programs, HHS will, where feasible, assess the results with data that measure program outcomes. However, as OMB Circular A-11, Part 2 anticipates, measures of output can be the predominant goals and indicators in an annual performance plan, and they are in the HHS plans.

Output and process goals and measures are important for the assessment of HHS programs, particularly in the early stages of GPRA implementation. Output and process measures are meaningful in their own right because they inform more completely about program "performance" than do outcome measures, which better assess program "results". Output and process measures also tend to be more practical and realistic, particularly for the annual assessment of programs that affect people. Measuring the impact of programs on families and individuals is expensive, as demonstrated by the costs of surveys on characteristics of populations; it is not likely that HHS would be able to finance such activity for numerous programs annually. In addition, for many health and human service programs, it is unrealistic to expect that meaningful changes in impacts on people would occur because of an individual program, or even be detectable or measurable on an annual basis. Where program partners, such as the States, must provide the data to assess program performance on an annual basis, it will be far less burdensome if we allow them to utilize existing administrative data bases and, therefore, process and output data. Finally, the most critical results for some program activities are not always outcomes. Frequently it is the processes associated with Federal programs, regulations and activities that have the greatest impact on people and industries; and improving the timing and quality of outputs and processes may be the most appropriate and effective objectives and performance measures for such programs.

Nevertheless, HHS is committed to pursuing the use of outcome goals and measures for its program activities where feasible. Some HHS components have initially made greater use of process and output measures than they will in the future because of the lack of adequate data to measure performance outcomes or the need to work with their performance partners to develop mutually agreed upon outcome goals and measures. As a result, we expect that future iterations of the HHS Annual Performance Plan will include more outcome goals and measures for some programs than the initial plan. A review of component performance information will identify where we expect these circumstances to occur.

Participation of Partners and Stakeholders

Because partnership in administration is a central and fundamental management approach for program implementation and service delivery for many HHS programs, it is critical for the Department to provide its partners substantive and authoritative participation in the development of performance objectives and measures. State and local agencies, non-profit groups, universities, insurance companies, health-care practitioners and numerous others in the community match, supplement or coordinate services funded by HHS and comparable service agencies. HHS's experience with performance measurement pilots and performance partnerships has demonstrated the significance of partners and stakeholders in developing performance goals and measures, and our reliance on them for much of the data that will serve to assess the results of HHS programs. Developing goals and measures in this in a manner is a prominent challenge for HHS, and has affected our ability to develop goals and measures in this first plan. The Medicaid waiver from OMB illustrates this. The challenge has also affected goals and measures for other program activities to a lesser but still significant degree. Our efforts to address this challenge are likely to result in significant changes to performance goals and measures in the first few years of implementation of the GPRA for program activities where partners participate extensively in program administration and financing.

Coverage and Aggregation of Program Activities

The HHS annual performance plan provides performance information for a mixture of direct and aggregated program activities, but coverage of major HHS program activities is complete. HCFA, NIH and ACF have aggregated program activities as permitted by the GPRA, and have explained the rationale for aggregation in their parts of the HHS plan. Others, such as HRSA, CDC and FDA have elected to provide performance information for all budget activities. For reporting and presentation purposes, there do not appear to be significant benefits or detriments to either approach. Both allow for substantive performance information that is meaningful to HHS and the Government as a whole.

PERFORMANCE GOALS AND INDICATORS

The performance goals and indicators for HHS's program activities are the most fundamental aspect of the FY 1999 HHS Annual Performance Plan. All HHS programs are represented in some fashion in the Annual Performance Plan by quantitative or qualitative performance goals and indicators, and many of these goals and indicators are related to program outcomes. HHS's annual performance goals and indicators, which are presented and explained in detail in the individual budget and performance plan submissions of HHS components, provide a portrait of what HHS and its program performance partners will achieve through HHS programs in FY 1999. In addition, the goals and measures go a long way toward explaining how resources administered by and through HHS are used, and what results are to be accomplished with these resources.

Although reviewers must refer to the budget submissions of HHS components for detailed performance information, this document provides a general description of the mission and programs of the agencies, how the performance goals and objectives of individual HHS components support the Department's Strategic Plan, and how these varied components have approached the implementation of GPRA requirements for annual performance plans. We also summarize the data challenges for each agency, reflecting the variety of challenges that HHS faces in measuring performance under GPRA. The following sections summarize pertinent information about performance assessment approaches and identify significant areas of performance objectives and measures that the HHS components have identified for FY 1999.

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

Overview

The Administration for Children and Families (ACF) administers programs that promote the economic and social well-being of children, youth, and families, focusing particular attention on vulnerable populations including low income children, refugees, Native Americans, and the developmentally disabled. These programs derive from dozens of legislative authorities and a diversity of funding and governance arrangements. ACF provides leadership, coordination, technical assistance, evaluation and Federal funding, and State, local, or community-based organizations or non-profit grantees deliver program services.

ACF and its partners are jointly responsible for the success of programs that provide primary support for the HHS strategic goal to:

> ***Improve the economic and social well-being of individuals, families, and communities in the United States.***

Working toward increasing the economic independence and productivity of families, improving the healthy development, safety and well-being of children, and building healthy, prosperous communities and Tribes, ACF and its partners have developed performance goals and measures that will track their success in increasing employment, independent living, affordable quality child care, parental responsibility, and improvements in the health status and safety of children and youth.

ACF also coordinates its programs with other HHS agencies, particularly those that provide medical and social services and health insurance to low income families, including the Health Care Financing Administration, Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration.

Other Federal agencies have related goals that complement and supplement ACF's goals, including the Departments of Labor (improving job readiness and employment among low income people), Housing and Urban Development (improving the quality and supply of inexpensive housing), Agriculture (assuring that the nutritional needs of low income people are met), Transportation (helping welfare recipients obtain affordable transportation to the workplace), Education (improving early education efforts and readiness to work skills), and Justice (supporting non-violence programs). ACF participates in a number of interagency workgroups that work to assure coordination among these programs.

Approach to Performance Measurement

ACF administers twenty-two programs divided among 35 budget activities. To encourage individual programs to collaborate and direct their efforts to achieve ACF-wide crosscutting

program goals, ACF aggregated these budget activities into thirteen major program areas that support four long-term goals. Under these goals, ACF established eight crosscutting objectives that will facilitate movement toward more outcome-based measures. These goals and objectives provide the structure for ACF's performance plan.

ACF's programs are administered in a complex partnership environment in which varying Federal, State, local, non-profit and community-based funding sources and programs develop and carry out programs, deliver services and strive to attain goals. The relationships, funding mechanisms and degrees of autonomy vary from program to program. A primary challenge is for partners to collaborate in crafting effective policies and programs that satisfy mutually agreed-upon objectives. The broad goals of these diverse jurisdictions and organizations are similar to ACF's, but State and local programs often differ on specific targets and outcomes relevant to the particular needs of specific population groups and communities. In this decentralized environment, ACF's ability to achieve its goals and objectives depends on working effectively with State, local, and tribal governments and other stakeholders.

Recognizing this, ACF has engaged in extensive consultation with its partners and stakeholders to develop and gain their support towards the achievement of mutually agreed-upon performance goals and measures, allowing for maximum flexibility at the local level. These discussions have included not only direct partners but also advocacy groups and national educational/technical assistance organizations. This effort to reach consensus on outcomes has prompted extensive discussion of strategic objectives, legislative requirements, and data sources and availability and has led to a fuller understanding of the desired program outcomes and the relationship of process and output measures to those outcomes.

The expected results and impacts will vary across goals and objectives depending on the nature of the issues, the identification of appropriate measures, and our ability to collect the data. In areas where results are quantifiable and where data are available or more easily obtained, such as for child support collections, ACF expects to report on results sooner. In other areas, where expected outcomes are qualitative or depend on the agreement of State and local agencies to provide data, considerable effort will be needed to achieve consensus on the appropriate outcomes and measures of success, and to design, develop, and implement appropriate systems for data collection. This is illustrated by ACF's efforts to establish a high performance bonus system under welfare reform, its efforts to measure quality in Head Start, and by the newly legislated expectations for child protective services, foster care, and adoptions.

Data Issues

ACF has identified a number of data issues that affect its ability to collect data to report on program performance, including the following:

* Quantitative and qualitative measurement of outcomes for social programs is in its infancy. For the most part, data collection systems that meet this need are not yet in place. States, Tribes and non-profit grantees vary in their ability to collect, produce and report reliable

data. Data validation and verification will be highly complex.

* The flexibility of States to vary program design affects not only the composition of some programs, but also our ability to match State and Federal programs for analytical purposes. For example, at one time, the AFDC and JOBS programs are no longer structure or titled the same from State to State. Variations in the terminology used to report program accomplishments from State to State hinders the ability of HHS and its partners to aggregate performance data.

* Baseline data are frequently unavailable for new or changed programs, and must be developed before progress can be measured.

* Investments for the design, development and implementation of data collection systems are costly and must be balanced against other priorities, at all levels—Federal, State and local.

ADMINISTRATION ON AGING (AoA)

Overview

The Administration on Aging (AoA) serves older persons and their families through the administration of the Older Americans' Act and aging-related applied research and educational projects. As the focal point in the Federal Government for advocacy for older persons, AoA works to advance the dignity and independence of the nation's elderly. Under the authority of the Older Americans' Act, AoA provides funds to support the operations of State and area agencies on aging that comprise the aging network, and also for support services to the elderly. The leveraging of services on behalf of the elderly is also an important role of AoA and the aging network, as significant services provided through the aging network are financed through other sources, including other Federal programs, State programs, local funds, and even program income received as donations by people who, for example, eat a meal at a congregate meal site. Through statewide service delivery infrastructures, AoA-funded programs provide comprehensive in-home and community services; and make legal services, counseling, and ombudsmen programs available to elderly Americans.

The results that AoA and the aging network seek to produce for older Americans, will contribute substantively to the achievement of the HHS strategic goal to:

> ***Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States.***

AoA will support the successful accomplishment of this goal through its programs that provide for advocacy, community-based access services, nutrition services, Native American services, long-term care ombudsman, research and demonstration programs, and the Alzheimer's disease grants. The grant funding provided under these programs helps to fill the gaps in other federal and State programs. It also supplements such programs by providing services to people who are ineligible for other programs but who still need support. Also, the ability of the aging network to leverage funds for services from sources other than AoA's funding under the Older Americans Act, is a critical function of the network, and one which contributes to improving the well being of elderly individuals in need.

Approach to Performance Measurement

AoA aggregated program activities in its performance plan to reflect service practices in the field where States, Indian tribes, area agencies on aging and providers seek to operate their programs for the elderly in a coordinated manner. The performance goals and measures in the plan primarily address the levels of service provided and leveraged by the aging network. The services that produce improved outcomes for older Americans are so fundamental that the measurement of service levels are a strong indicator of program success. The aging network does not have to measure the effect of quality food on the health of older Americans in need; providing that food

improves the health of these individuals. The network does not have to measure the effects of home-based services or transportation on the independence of older Americans; such services allow them to maintain their independence. As a result, the aging network seeks to achieve improved outcomes for the elderly through increased capacity and effective use of comprehensive and coordinated service systems. Appropriate measures of performance for programs for the elderly center on the levels of service provided for program education, personal assistance, transportation, and case management. Reflecting this basic focus on successful performance for older Americans, AoA has identified primarily output measures that reflect the level of services provided through the aging network.

The output measures identified by AoA contribute to successful outcomes for older Americans. For instance, the FY 1999 provision of 119 million home-delivered meals to over 988,000 people under the nutrition program directly contributes to the daily health and independence of older Americans. The long-term care national resolution and partial resolution rate of more than 70% for complaints facilitated by ombudsmen will help to ensure that safe, quality long-term care is provided.

AoA measures its own accountability for its contribution to the health and independence of older Americans by improvements in the timely and accurate processing of grants, as well as improvements in its corporate data structure that supports its programs.

Data Issues

To assess the performance of the network and itself, AoA will use the state and tribal program reports for Titles III, VI, and VII of the Older American's Act. These systems comprise the National Aging Program Information System (NAPIS). Begun in 1997, the NAPIS collects for the first time, unduplicated counts of recipients of services with breakdowns by cost, age, and ethnicity. The results of the initial reports under this system affect the baselines and targets identified by AoA. This data is aggregated information about program outputs, so it will be adequate for assessing the output performance measures. It does not report on outcomes, however. These reports will be supplemented by site visits and surveys.

AoA based several of its measures on a study of community-based services, and evaluation studies of nutrition services and the long-term care ombudsman program. AoA has begun planning for the evaluation of supportive services and senior centers under Title III of the Act.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR)

Overview

As the lead agency for health-care quality in HHS, the Agency for Health Care Policy and Research (AHCPR) supports and conducts research to improve the quality, accessibility, cost and utilization of health care services. Through evidence-based research, AHCPR improves the care that clinicians provide, and empowers consumers to make better health-care choices. AHCPR also tracks the health of the nation through data collection and analysis, and helps public and private decision makers better manage the nation's health-care industry.

AHCPR works with the public, private sector organizations, experts, and internal and independent researchers to identify the needs for new knowledge, products, and tools. AHCPR then sponsors and conducts the research, disseminates the information that results from the research, and evaluates the impact. AHCPR's research is also a key source for the knowledge used by other components of the Department to make decisions which carry out their missions. HCFA for example, can use AHCPR research to perform its role in overseeing the cost and quality of medical services to Medicare beneficiaries.

Because AHCPR is the focal point of the Department's health care quality efforts and because it provides new knowledge on what works at what cost in the health care system, AHCPR makes important contributions to the HHS strategic goals, particularly the HHS strategic goals to:

Improve the quality of health care and human services;

Strengthen the nation's health sciences research enterprise and enhance its productivity.

AHCPR's key strategies in FY 1999 for contributing to these goals are to:

- Conduct research to address the challenges of current health care changes and developments.
- Coordinate and provide information that focuses on questions of great public policy interest.
- Exercise leadership for the crosscutting interagency efforts to improve the quality of health care.

AHCPR will use the resources provided in its budget activities of Research on Health Costs, Quality and Outcomes (HCQO), Medical Expenditure Panel Surveys (MEPS) and Program Support to conduct these strategies and to work toward these HHS strategic goals. Research grants and survey mechanisms as well as collaborations with partners are the vehicles for these resources and for accomplishing these strategies. For example, grants awarded for investigator-initiated research in FY 1999 are expected to address developments in the purchasing behavior of large employers and purchasing coalitions; changes in structure, financial mechanisms, and legal and regulatory framework of the health industry; new models of delivery of health care; "medical necessity" coverage issues; and the capacity to provide a coordinated package of services for

patients.

Approach to Performance Measurement

AHCPR has defined performance goals to assess the results of research performed on health costs, quality, and outcomes. The agency acknowledges that outcomes of research programs are difficult to accurately measure and describe. Nevertheless, the plan identifies the expected results of research performed and due to be completed in FY 1999, which will add to the knowledge base of what works and at what cost. The plan proposes to assess how the agency translates this knowledge into practice through the development and provision of information, products, and tools for use in operational settings. AHCPR proposes an initial step to identify the outcomes of the AHCPR research and information that has been put into practice. Finally, the AHCPR plan covers the assessment of its efforts to provide leadership for improvement in the quality of health care.

AHCPR includes a performance goal that specifically addresses the MEPS program activity. Because the purpose of MEPS is to collect detailed information regarding the use and payment for health care services from a nationally representative sample of Americans, process and output indicators are appropriate to ensure that timely data is available.

Data Issues

AHCPR also will use a variety of mechanisms to validate the information and data presented to describe what has been achieved for the indicators. A great deal of the information needed relates to the funding and results of research. AHCPR financial and grants management computer systems automatically collect much of this information. Many Agency activities (e.g., tool development) have evaluation components built directly into the projects. Where there are no tracking systems in existence, e.g., the training of future researchers, AHCPR will also undertake an evaluation study to determine the impact of AHCPR-sponsored and conducted research on the health care system. Finally, as the results of the assessment activities are produced, the Agency will evaluate whether the right indicators are being used to measure its success.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Overview

The Centers for Disease Control and Prevention (CDC) is the lead federal agency that promotes the health and quality of life by preventing and controlling disease, injury, and disability. To accomplish its mission, CDC collaborates with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public leadership and training.

CDC exercises leadership in concert with other federal, state and local agencies, tribal nations and private organizations. All of these partners contribute to the successful accomplishment of the HHS strategic goals, and in particular those to:

Reduce the major threats to health and productivity of all Americans;

Improve public health systems;

Strengthen the nation's health sciences research enterprise and enhance its productivity.

In FY 1999, through its programs in Environmental Health, Infectious Disease, Occupational Safety and Health, Epidemic Services, and the Prevention Centers, CDC will continue to support the HHS strategic goal of a public health science base by conducting its own research and providing the funding for extramural research. CDC will also support the HHS strategic goal of improving public health systems by working with its partners at state and local health departments and with non-governmental organizations at the community and national levels to design, implement, and evaluate sound prevention programs. CDC funding also will help state and local health departments to build their capacity to reduce sexually transmitted diseases, HIV/AIDS, tuberculosis, vaccine preventable diseases, breast and cervical cancer, diabetes, injuries, and childhood lead poisoning.

In addition, CDC contributes to the HHS strategic goal for the reduction of major health and productivity threats by continuing to fulfill its unique role of providing timely, comprehensive information on current health issues and problems through the Health Statistics program. Health threats are also detected and assessed by CDC's Preventive Health and Health Services Block Grant, Epidemic Services, and Cancer Registries programs. Environmental health threats are addressed via a collaborative partnership between CDC, the Agency for Toxic Substances and Disease Registry, the Environmental Protection Agency, and the National Institute of Environmental Health Services.

Approach to Performance Measurement

In its performance measurement strategy, CDC identifies the purpose, objectives, performance measures, partnership opportunities and data collection methods for each program activity. Since the agency's program activities complement each other, the plan is organized into functional areas of infectious diseases, immunization, health statistics, chronic disease prevention, prevention research, preventive health and health grants, and injury prevention and control. The infectious disease function, for instance, includes several disease prevention programs: Emerging Infections, Tuberculosis, HIV/AIDS, and Sexually Transmitted Diseases.

Available data allow CDC to identify outcome performance measures for many of its programs. A number of them are based on the Healthy People 2000 goals and objectives. CDC therefore identifies outcome measures for reducing diseases such as tuberculosis, HIV/AIDS, sexually transmitted diseases, and vaccine preventable diseases.

Where it is not possible to identify specific reduction targets and measures, CDC has committed to and has included the rationale for output and process measures. Many of these output and process measures concentrate on CDC's efforts to help improve detection and prevention programs in state and local health departments.

Data Issues

CDC is fortunate in that strong data collection and analysis capabilities are embedded throughout the agency. It will use a variety of data sources, including:

Data from states funded by CDC;
On-site technical assistance visits;
National reporting systems (such as the National AIDS Reporting System, the National STD Surveillance System, National Birth Defects Surveillance Network);
National surveys (such as the National Health Interview Survey);
Contractor reports, published data, studies, and recommendations;
State-based systems such as the Behavioral Risk Factor Surveillance System;
Reports on Internet use of CDC's WONDER tracking system; and
Reviews of annual reports, policy documents, and profiles.

The frequency of data collection varies; some proposed measures rely upon on-going quarterly report data, while others may represent annual collection efforts.

Verification and validation of performance is discussed in each program activity. Since much of the performance data is obtained from states, grantees, and contractors, there will be a mix of site visits, progress reviews, and publication reviews to verify the data.

FOOD AND DRUG ADMINISTRATION (FDA)

Overview

As the principal consumer protection agency of the Federal Government, FDA protects the public health through the prevention of injury and illness due to unsafe or ineffective products. FDA operates to identify health problems associated with FDA-regulated products and assess the origin and impact of these health problems. FDA makes every effort to prevent problems that would expose the public to hazards and monitors the marketplace to ensure compliance with laws and regulations protecting consumers.

The programs of the Food and Drug Administration protect and promote the health and safety of the American people by the regulation of foods, cosmetics, human and animal drugs, animal feed, tobacco, and biological products and devices used for medical purposes. The role of FDA is prominent in the achievement of the HHS strategic goals to:

Reduce the major threats to the health and productivity of All Americans;

Improve the quality of health care and human services;

Improve public health systems;

Strengthen the nation's health sciences research enterprise and enhance its productivity.

FDA seeks to respond rapidly and effectively to the nation's need for new and safe drugs, biologics, and devices. To achieve this in a downsizing environment, FDA is changing the way it has traditionally dealt with pharmaceutical and medical industries by solving potential problems at the front-end to accelerate transit through its approval processes. At the same time, FDA also interacts with consumer groups to ensure that all approvals are based on rigorous and appropriate scientific conclusions.

To address the current needs of consumers, FDA must coordinate its consumer protection approaches and activities with other Federal agencies that work in partnership to achieve the fundamental goals FDA pursues. Food safety provides an illustration of cross-cutting activities. Changing consumer patterns have meant that the demand for produce has increased to become year-round, resulting in the importation of more food items. FDA has had to adapt its resources accordingly to meet this need which has resulted in increased interaction with the Customs Service. Domestically, FDA is increasing its interaction and coordination with USDA, CDC and EPA as part of a recent food safety initiative, which emphasizes the use of hazard analysis and critical control point programs. Recently, FDA has also had to address the rapidly changing tobacco environment, in which it will operate in concert with other HHS operating divisions (CDC, SAMHSA, and HRSA), other Federal agencies and the states. FDA will continue to

develop its performance planning to include joint performance goals with its partners.

Approach to Performance Measurement

FDA's programs and activities alone cannot ensure the safety of food, drug and medical products; the industries that the agency serves and regulates, and consumers also, have a prominent role in achieving those outcomes. However, the effectiveness of FDA's activities and processes are critical to the achievement of these outcomes. FDA's approach to its performance plan has been to include performance goals and measures that address its interaction with the entire food and drug continuum. There are measures for the actions that FDA takes in the execution of its programs (process), the results of its regulatory actions (output), as well as some outcome measures. FDA has numerous goals that address the efficiency of review time for food, new drugs, biological products and medical devices, as well as efforts to ensure that manufacturing establishments for these products conform to FDA standards. There are some outcome measures such as the usage of food labels in making nutritious food and reduction in risky food handling and consumption practices. FDA also included measures for the underlying processes and research that support these efforts. FDA adopted the spirit of the Results Act and extensively involved program managers, who have the most detailed knowledge, in the development of its goals and measures.

Data Issues

FDA recognizes that the safety and effectiveness of foods, drugs and medical products (outcomes) are the primary concern of the American taxpayer. The development of additional outcome measures has been a challenge for FDA as it does not yet have extensive processes and systems in place to measure and evaluate many outcomes. FDA will give greater emphasis to outcomes in the future and to the establishment of more external partnerships to achieve these outcomes.

For FY 1999, FDA will use a combination of existing and newly designed databases to assess progress in achieving its goals. Many databases are collaborative efforts between other Federal and states agencies, consumer and industry groups. Others are exclusive to FDA. In 1998, FDA will initiate a verification and validation system to help program managers monitor progress toward achieving FDA's goals. This system will include training to learn essential aspects of performance measurement, a checklist for verifying and validating goals, and assistance in applying performance data in reporting and management.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Overview

Through the administration and management of the Medicare and Medicaid programs, it is the fundamental mission of HCFA and its partners to ***"...assure health care security for beneficiaries."*** Under basic program authority, HCFA pays Medicare benefits through private fiscal agents; provides States with matching funds for Medicaid benefits; conducts research, demonstrations, and oversight to ensure the safety and quality of medical services and facilities provided to Medicare beneficiaries; and establishes rules for eligibility and benefit payments.

HCFA, State Medicaid Agencies, Medicare fiscal agents, and health-care providers who serve Medicare and Medicaid beneficiaries are significant performers in the successful attainment of four HHS strategic goals, but particularly of the HHS goals to:

> ***Improve access to health services and assure integrity of the nation's health, entitlement and safety net programs;***
>
> ***Improve the quality of health care and human services.***

The Medicare and Medicaid programs administered by HCFA in partnership with the States and the health care industry nationwide are the two of the most significant programmatic mechanisms for ensuring access to quality care for the populations served by HHS programs. Through these programs and their projected outlays in FY 1999 of $347 billion, an estimated 72 million Americans will not only have access to but will receive top-quality health care.

HCFA's performance goals and indicators also accentuate the Department's commitment to address the identification and resolution of significant management challenges, particularly in its efforts to eliminate fraud, abuse and mismanagement in Medicare and Medicaid. HCFA addresses this major HHS management challenge and high-risk area with goals and measures to reduce fraud, particularly in the vulnerable home-health sector, to reduce improper payments, and to increase electronic transactions that are less prone to problems.

Approach to Performance Measurement

Two principles characterize HCFA's approach to performance measurement. First, HCFA will pursue performance goals that are representative of program performance. HCFA's performance plan consists of a manageable set of performance goals and measures that is consistent with strategies recommended by OMB and GAO for measuring program performance. More significant to HCFA, however, and to the agency's contributions to the accomplishment of the strategic goals of HHS is the second principle of HCFA's performance measurement philosophy: ***"The most important things to measure relate to ensuring that Medicare and Medicaid beneficiaries receive the high quality care they need."***

HCFA has identified 22 performance goals for FY 1999 that are subdivided into three levels of activity centered around beneficiary service and support. The HCFA measures that are most closely aligned with beneficiaries directly, and thus are more outcome oriented, are at the core of the Agency's approach to performance measurement and constitute the ***first level*** of measurement focus. These core goals are accompanied by performance measures that focus on three dimensions of beneficiary impact: **access to care, satisfaction, and content of care**. The ***second level*** of goals and accompanying measures supplements the core beneficiary-centered measures. These are also closely related to beneficiary impacts, and in some cases are considered proxies for the core beneficiary-centered measures. For example, measurement of beneficiaries' receipt of influenza vaccines and mammograms are both direct measures of HCFA quality efforts, but also are considered supplemental proxy measures of beneficiary access to care. The ***third level*** of measures rounds out HCFA's approach by incorporating measures that are of the "output" variety and are more closely aligned with administrative functions. An example of a measure in this third level relates to improvements in payment safeguard strategies.

This three-tiered approach to performance measurement provides comprehensive coverage of Medicare and Medicaid as well balance among types of performance measures. HCFA has focused on identifying a set of significant meaningful performance measures that speak to its fundamental program purposes, and also incorporates key output-oriented measures that tie to administrative budget activities.

Data Issues

For the most part, the performance goals and measures in the HCFA plan are based on data that are currently available. As a result, HCFA does not anticipate the need for new information collections for the FY 1999 annual performance plan. For HCFA measures that are still under development, however, future new information collections may be required.

For several measures, HCFA does utilize survey data or evaluations/special studies that are conducted by other Federal agencies. For example, HCFA relies on surveys conducted by the National Center for Health Statistics and audits of the Office of Inspector General for some measures. HCFA will necessarily rely on these agencies to verify and validate their own data.

HCFA is currently consulting with its State partners on Medicaid performance goals and information. Data issues are a major element under discussion in these consultations.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Overview

The Health Resources and Services Administration operates to improve the Nation's health by assuring equitable access to comprehensive, quality health care. Fifty million or more Americans face serious barriers to receiving care. Forty-two million have no health insurance. Others qualify for Medicaid, Medicare or private insurance, but whether they live in a city or in a rural setting, have limited access to a doctor, nurse or other primary care provider. Still others have HIV/AIDS or another health condition that makes basic health care more critical, but less accessible.

HRSA operates programs that contribute to and support several Department strategic goals, particularly those to:

Reduce the major threats to the health and productivity of All Americans;

Improve access to health services and assure the integrity of the nation's health, entitlement and safety net programs;

Improve public health systems;

To improve access to health services, the HRSA-supported network of primary care health centers will increase the number of persons receiving primary care services--preventing disease and treating illness--in underserved areas. Through the Maternal and Child Health Block Grant, HRSA and states will increase the percent of pregnant women receiving prenatal care beginning in the first trimester and reduce the infant mortality rate. The Ryan White CARE Act programs will increase the number of people served, with a special emphasis on women, people of color and youth. HRSA also funds a variety of community-based programs to train the next generation of physicians, nurses and other health professionals, and has objectives to increase both the percent of minority and disadvantaged graduates and the overall number of health care workers serving in underserved areas.

HRSA has emphasized its linkages and partnerships with a variety of Federal and external partners; collaboration will continue to be HRSA's way of doing business. HRSA and the Health Care Financing Administration are jointly implementing the Children's Health Initiative, with particular focus on the new State Children's Health Insurance Program. With the Centers for Disease Control and Prevention, partnership activities are focused on a variety of disease prevention and health promotion activities, including immunization efforts and improved data collection and analysis. HRSA works with the Substance Abuse and Mental Health Services Administration on linking primary care services with services related to substance abuse, particularly given the close linkage between substance abuse and high rates of HIV infection.

HRSA distributes the majority of its funds through grant programs (categorical and block) and is pursuing partnerships with a variety of grantees and other external organizations such as State and local governments, non-profit health organizations, academic institutions, foundations, national associations, and business groups. HRSA will continue to partner with state, local and non-profit organizations on ways to assure that programs meet the needs of the underserved. Work with States and communities forms the foundation for developing integrated service systems and the appropriate health workforce to help assure access to essential high-quality health care. The agency will need to leverage existing resources, work more creatively with established partners, and plan closely with new partners at all levels to assure the highest degree of coverage possible for the populations-at-need.

Approach to Performance Measurement

HRSA has made a strong effort to build a performance management approach into the way it conducts its business. It has emphasized three goals:

- Access to comprehensive, timely, culturally competent and appropriate health care services for all underserved, vulnerable and special needs populations.

- Disparities in health status and health outcomes for underserved, vulnerable and special needs populations.

- Quality care provided to the underserved, emphasizing a diverse, quality work force and the use of emerging technologies.

Performance measurement capabilities currently vary among the agency's six major components and 50 programs. Consequently, HRSA's performance plan contains a mix of process, output and outcome goals and indicators focusing on programs' internal activities (e.g., training approach used), direct products or services (e.g., number of people provided health services, number of people trained), and the results of program output (e.g., changes in health status, mortality or morbidity).

Data Issues

There are numerous concerns about the availability, burden and cost of data to measure performance and results. HRSA has several efforts underway to increase the use of common, structured and standardized data strategies to carry out performance measurement. The issue of competing needs to collect essential performance measurement information while meeting the requirements of the Paperwork Reduction Act that must be addressed.

INDIAN HEALTH SERVICE (IHS)

Overview

The Indian Health Service administers the principal health program for American Indians and Alaska Natives (AI/AN) by providing prevention and treatment health services through a system of IHS, tribal, and urban operated facilities and programs. Improving the health status of AI/AN populations indicates IHS support of several HHS strategic goals, but it is a specific strategic objective under the HHS strategic goal to:

> ***Improve access to health services and assure integrity of the nation's health, entitlement and safety net programs.***

In addition, IHS efforts to prevent and treat alcohol dependence continue to be a special area of emphasis for the agency and an important component of the HHS strategic plan objective to curb alcohol abuse.

IHS provides health services to 1.5 million American Indians and Alaska Natives. The range of services includes inpatient and ambulatory care, and extensive preventive care, including focused efforts toward health promotion and disease prevention activities. Tribes who have elected to retain the Federal administration of their heath services, or to defer tribal assumption of IHS programs until a later time, receive 63 percent of the IHS funded services. Indian tribes deliver 37 percent of the IHS funded services to their own communities. Particularly since FY 1993, there has been a significant transition to tribal management of health programs under Title I and III of the Self-Determination legislation. Another integral part of both approaches is the purchase of services from non-IHS providers to support, or in some cases in lieu of, direct care services. Contract health services, composed of both IHS and tribal components, represent about 16 percent of the IHS budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding.

Approach to Performance Measurement

The IHS performance plan includes 25 performance indicators that are consistent with the IHS history of focusing on health improvements for the population it serves. The indicators were developed in partnership with tribal representatives, the agency's most important stakeholders. The performance indicators represent sentinel indicators for the IHS in that they are specifically focused on the 12 most significant health problems affecting AI/ANs, and/or the essential services that address them. These problems include: diabetes, obesity, cancer, heart disease, alcohol and substance abuse, family abuse and violence, injuries, dental diseases, poor living environment, mental health, tobacco use, and maternal and child health. They all represent important links in the GPRA/Public Health process directed towards outcomes. Some represent primary prevention that attempts to prevent a disease or condition before it occurs (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are "secondary preventive" in nature in that

they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., reducing diabetic complications). Given that there are no effective cures for many of the major health problems, the focus of IHS is to intervene early in the processes that contribute significantly to mortality and morbidity, rather than target end point problems such as heart attacks and stroke. This is the approach that has resulted in the improvements in health status of AI/AN people.

IHS has included indicators that assess how its consumers perceive the quality of and access to services, and how its stakeholders perceive its performance in assuring adequate consultation and advocating for the needs of AI/AN people. IHS has also developed indicators addressing its effectiveness in building collaborative relationships with other organizations and meeting its obligations as an Agency in the Department.

Data Issues

IHS utilizes outside (non-IHS) and IHS data sources to manage its diverse programs and assess Indian health status. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the decennial census, every 10 years. The NCHS provides IHS with natality and mortality files that contain all births and deaths for U. S. residents, including those identified as American Indian or Alaska Native. The data are subject to the degree of accuracy of reporting by the States to NCHS. The NCHS does perform numerous edit checks and imputes values for non-responses. Several studies have shown that there is considerable miscoding of Indian race on death certificates that understates Indian mortality especially in areas not associated with Indian reservations. While the IHS has developed some techniques for adjusting for miscoding, the chief limitations of mortality data are associated with time lags, i.e., the data are not typically available from NCHS until three years after the events occur and mortality data are slow in showing the impact of health interventions.

The IHS has its own program information systems to collect data on the services provided by IHS and tribal direct and contract programs. Since Indian tribes deliver 37% of services, they are crucial players in the data reporting system. Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse. These data are subject to recording, inputting, and transmitting errors. However, IHS software systems have extensive edits to detect and correct errors. Others that cannot be detected by computer are often discovered through the monitoring performed in the field and IHS headquarters. Some IHS measures rely on data not transmitted to the IHS central database. IHS is developing software to allow transmission of these data to the central database. In the meantime, IHS will use sampling routines to collect the required data from the individual facility-level databases.

NATIONAL INSTITUTES OF HEALTH (NIH)

Overview

NIH programs and activities are central to the mission of HHS to foster sustained advances in the sciences underlying medicine and public health. Through its related mission to sponsor and conduct research that leads to better health for all Americans, NIH supports three of the Department's strategic goals to:

Reduce the major threats to the health and productivity of all Americans;

Improve public health systems;

Strengthen the nation's health sciences research enterprise and enhance its productivity.

NIH has determined that a *combination* of qualitative and quantitative performance goals and indicators will provide the most meaningful and appropriate basis for GPRA assessments of NIH's programs.

Approach to Performance Measurement

NIH has aggregated its program activities for performance measurement purposes into three categories of activity: the **Research Program**, the **Research Training and Career Development Program**, and the **Facilities Program**. For the **Research Program**, qualitative measures will of necessity play a primary role in gauging NIH performance in achieving advances in science to meet that aspect of the HHS mission. For example, narrative descriptions of research accomplishments will provide perspectives about the contributions of scientific advances to understanding and improving health. The descriptions will provide a sense of the place of advances in science in the continuum of medical research. Where possible, the economic impact of advances in science will also be addressed, and quantitative indicators will also be employed.

Evaluations of the **Research Training and Career Development** and the **Facilities** programs better lend themselves to quantitative measures, and NIH has included quantitative measures for these programs. However, quantitative measures alone do not provide an informed basis for judging program success, so a mix of quantitative and qualitative indicators will be utilized. NIH's approach is consistent with that of other research agencies actively implementing the provisions of GPRA. It is neither feasible nor sufficient to capture the breadth and impact of such research activities through strictly numeric goals and measures. Conventional scientific research metrics measure only some dimensions of output. These measures provide relevant data, but are insufficient for generating the necessary, larger picture of the quality, relevance, and impact of an overall research program. As the General Accounting Office, the President's Office of Science and Technology Policy (OSTP) and numerous others who have studied the processes of science and technology and innovation have noted, the linkages between inputs and outputs in basic

science (the predominant share of NIH's activities) are complex, can take many years to reach fruition, and, very often, are difficult to accurately anticipate in advance. Research agencies should rely on a combination of quantitative and qualitative measures to assess performance under the GPRA.

Data Issues

Because of its necessary reliance on qualitative data, which NIH will make available to measure outcomes relating to its performance, the collection, organization and presentation of performance information will be labor and resource intensive. Data on scientific advances will require scientific review and will need to be merged with pre-existing data which will require considerable time and effort to ensure the reliability and validity of the data. Data will need to be analyzed and coupled with qualifying information to ensure that it is accurate and meaningful. New surveys and program evaluations will need to be conducted to supplement existing databases. It will also be necessary for the NIH to consult with its constituents and the many investigators affiliated with the research facilities across the country. The effort of this performance measurement process is primary data issue for NIH, but it is necessitated by the fact that qualitative assessment of research activity is essential for effective performance assessment.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Overview

SAMHSA's mission within the Nation's health system is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring substance abuse and mental disorders, in order to improve health and reduce illness, death, disability, and cost to society. SAMHSA's priorities are to:

- Identify and monitor gaps in treatment and prevention services;
- Make progress toward closing those gaps on a national, Statewide, and local basis; and
- Provide targeted support for the development and proliferation of services which address the needs of children and their families.

SAMHSA has an important role in supporting several HHS strategic goals, particularly those to:

> ***Reduce the major threats to the health and productivity of All Americans;***
>
> ***Improve access to health services and assure the integrity of the nation's health, entitlement and safety net programs;***
>
> ***Improve the quality of health care and human services;***
>
> ***Strengthen the nation's health sciences research enterprise and enhance its productivity.***

SAMHSA efforts to reverse the upward trend and use of marijuana among 12-17 year olds and reduce tobacco use among teens and preteens are integral to the Department's strategic goal to reduce major threats to the health and productivity of all Americans. Of similar significance are SAMHSA's activities to support prevention and early intervention for substance abuse. HHS's goal to assure access to needed services is supported by SAMHSA's efforts to implement effective systems of care for children with serious emotional disturbances. SAMHSA, through its Knowledge Development and Application (KD&A) program, is sponsoring a number of research projects which test prevention, treatment and delivery approaches in support of the HHS goal to improve the quality of health care.

SAMHSA's support of HHS goals, and achievement of its mission and objectives are accomplished in two ways. First, it plays an important leadership role in developing national policy. Second, it pursues national goals through grants, cooperative agreements, contracts, and interagency agreements with Federal, State, local, university, provider, consumer, family, and

other types of entities. Through the substance abuse and mental health block grants and the two mental health formula programs, SAMHSA provides direct funding to States to support services, with considerable State discretion over how funds are used. SAMHSA's KD&A effort is a highly focused program of small, applied research projects to answer questions that have been identified by SAMHSA's customers as critical to the improvement of services at the point of delivery.

SAMHSA works with a broad array of partners and stakeholders, including State and local governments; providers; consumers/clients of substance abuse and mental health services; family members of individuals with substance abuse or mental illness; grantees; other Federal agencies; foundations; and a variety of volunteer and other organizations that do not fall within the categories mentioned.

The agency also relies heavily on interagency collaborations to accomplish its goals. Other HHS agencies with which SAMHSA collaborates include the Health Care Financing Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health. SAMHSA also works with the Office of National Drug Control Policy; the Department of Education; the Department of Veterans Affairs; the Department of Justice; the Department of Transportation; the Department of Housing and Urban Development; and the Department of Defense.

Approaches to Performance Measurement

The SAMHSA performance plan is organized around its program areas (i.e., substance abuse and mental health) and its funding approaches (i.e., grants, research projects). In all cases, constraints exist in the current state-of-the-art of performance measurement. The need to develop outcome performance measures for these fields is supported by the 1997 report of the National Academy of Sciences entitled "Assessment of Performance Measures for Public Health, Substance Abuse, and Mental Health." SAMHSA is working with States and other partners to address this issue. In addition to the difficulty and expense in identifying and collecting data for appropriate outcome measures, health systems must choose between sustained investment in this effort and using the same dollars to fund additional services.

Three SAMHSA pilot projects currently assist States to develop performance measures for the public service systems they administer. It is hoped that these measures, once developed and supported by reliable data, will serve as outcome measures for SAMHSA's block grants. A feasibility assessment project fore mental health services has been initiated in five States. A second project is developing a minimum data set for substance abuse prevention that will lead to performance data at the State level that could also be aggregated at the national level. Cooperative agreements in the area of substance abuse treatment are assisting State grantees to identify, assess, and adopt core performance measures and indicators. Finally, the expanded National Household Survey of Drug Abuse will complement these performance outcome measures development efforts by providing State-level estimates of the incidence and prevalence of drug abuse.

For KD&A projects as a whole, SAMHSA will rely on a mix of generic measures, including stakeholder assessments of the relevance and usefulness of topics, and for work products, their timeliness, reliability, and compliance with research standards. SAMHSA has developed some preliminary outcome measures for some KDAs associated with mental health and prevention efforts. For addressing the KD&A issue of translating knowledge and best practices into positive consumer outcomes, SAMHSA has developed appropriate intermediate outcomes including customer ratings of the appropriateness and usefulness of the products and direct adoption of new approaches by SAMHSA-funded entities.

Data Issues

SAMHSA has actively pursued the development of outcome measures for all of its programs. However, the cost to States and to the Federal Government of developing and implementing data and other measurement systems for the block grants is expected to continue to be a significant factor in the ultimate success of these efforts.

PROGRAM SUPPORT CENTER (PSC)

The Program Support Center's mission is to provide a wide range of support and administrative services to components of the Department and other Federal agencies. The PSC is a business-type operation that provides human resource, financial management and administrative services to its customers.

The broad goals of the PSC's annual performance plan focus on improving the cost competitiveness and quality of its services. These goals and the specific performance objectives in the plan are linked indirectly to the goals of the HHS strategic plan. By achieving its goals and objectives, the PSC will provide services that enhance the capabilities of HHS program components to meet their missions and programmatic goals and objectives. In FY 1999, the PSC will reduce the unit costs for a number of services by consolidating operations, automating more of its workload and increasing its client base. The PSC will also improve customer satisfaction by improving the overall quality of operations and responding to customer priorities and concerns. High quality and less costly internal operations will help HHS programs and agencies to concentrate more attention and resources on achieving results and resolving programmatic issues.

OFFICE OF THE SECRETARY (OS)

Two components within the Office of the Secretary with programmatic responsibilities, the Office for Civil Rights and the Office of the Inspector General, have prepared Annual Performance Plans. Four Staff Divisions, encompassing almost 70 percent of the total Departmental Management funding, have prepared performance information (i.e., performance goals and measures). The four divisions are the Office of Public Health and Science, Assistant Secretary for Management and Budget, Assistant Secretary for Planning and Evaluation and the Departmental Appeals Board. OCR's performance objectives are primarily supportive of the Department's strategic goal to improve access by identifying and eliminating discriminatory practices in HHS programs and by HHS grantees. The OIG's primary link to the HHS Strategic plan is to assure the integrity of the Nation's health entitlement and safety net programs. While the OIG will be deterring fraud, waste and abuse, the Office will also be recommending systemic improvements to HHS programs which will indirectly assist in these programs in meeting their own programmatic performance goals and objectives. The submissions from the OS Staff Divisions represent first good effort by components not usually included in performance measurement initiatives. Many of the ASMB performance objectives address high priority management areas (e.g., improving grants and contracts administration and financial management, achieving progress in implementing GMRA and ITMRA).